



**ONSITE RADIOLOGIST  
ASSIGNMENT OF PROCEEDS/LIEN FOR MEDICAL SERVICES  
HIPAA AUTHORIZATION**

<b>ONSITE RADIOLOGIST</b> MRI – CT – Ultrasound <a href="http://www.onsiteradiologist.com">www.onsiteradiologist.com</a> <a href="mailto:info@onsiteradiologist.com">info@onsiteradiologist.com</a>	3547 Peachtree Industrial Blvd. Suite # 4 Duluth GA 30096  <b>770-299-1332 / 770-299-1344</b>  <b>770-741-0097</b>
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<b>ATTORNEY NAME:</b> _____  <b>ADDRESS:</b> _____ _____ _____  <b>PHONE:</b> _____  <b>DATE OF INJURY:</b> _____	<b>PATIENT NAME:</b> _____  <b>ADDRESS:</b> _____ _____ _____  <b>PHONE:</b> _____  <b>PATIENT SSN:</b> _____ <b>DOB:</b> _____
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In consideration of services rendered and to be rendered unto me by ONSITE RADIOLOGIST and its affiliated medical care providers, I hereby irrevocably assign, convey and transfer unto Onsite Radiologist a vested interest in (and the right of action against anyone responsible for medical expenses) the proceeds of any judgement or settlement in the lawsuit or claim which I am prosecuting to recover damage for my injuries. This assignment of interest is for current medical imaging services as well as any future imaging services provided.

I further authorize and empower and instruct my attorney to deduct immediately from the proceeds of any settlement and/or judgement, any and all amounts due and owing to Onsite Radiologist without further authorization from me, and to forward these payments directly to Onsite Radiologist. This authorization is complete and irrevocable and in consideration of these services rendered by Onsite Radiologist, for which services I am financially responsible.

I understand that, in accordance with the Health Information portability and Privacy Act of 1996 (HIPAA), my medical information may be shared in order to manage and expedite my medical care. I authorize Onsite Radiologist and its affiliated medical providers to secure, release and disclose such medical information as provided to them herein. My signature is an acknowledgement that I have received a copy of this authorization/assignment (upon request).

\_\_\_\_\_      \_\_\_\_\_  
 Signature of Patient or Legal Representative      Date

The undersigned Attorney for the above patient hereby agrees to observe all terms stated herein and agrees to withhold from any settlement, judgement or verdict sums adequate to protect Onsite Radiologist for its outstanding medical imaging bills. Attorney agrees to hold such sums in Attorney's Client Trust Account. Attorney further agrees to honor this medical lien and to pay said sum directly to Onsite Radiologist from Attorney's Client Trust Account in accordance with the laws of the state of Georgia (GA Code 44-14-470 etseq.). If Patient secures new counsel, Attorney agrees to inform new counsel of this agreement and to inform Onsite Radiologist of this change in counsel. Failure of Attorney to Sign and return this document to Onsite Radiologist does not release Attorney's responsibility to honor this medical lien.

Attorney Signature: \_\_\_\_\_ Date: \_\_\_\_\_